



Patient Safety October, 2003

1: Am J Emerg Med. 2003 Oct;21(6):461-6.

Epidemiology of adverse effects of prehospital sedation analgesia.

Ricard-Hibon A, Chollet C, Belpomme V, Duchateau FX, Marty J.

The aim of this study was to introduce a continuous monitoring of side effects related to sedation-analgesia in the field. A document was completed by physicians on board the ambulances for all prehospital interventions and checked daily by the medical staff. A total of 3605 interventions were evaluated over a 12-month period. Six hundred four patients undertook analgesia and/or sedation: group 1 (spontaneously breathing patients) n = 289 and group 2 (intubated-ventilated patients) n = 315. Sixty-four percent of patients received intravenous opioids in group 1. The anesthetic technique used for intubation was the rapid sequence induction in 70% of patients. Side effects were observed in 5.5% in group 1 (nausea: 2%, hypotension: 1%, hypoxemia: 1%) and 22% of patients in group 2 (hypotension-arrhythmia: 12%, cardiac arrest: 2%, difficult intubation: 5%, hypoxemia: 1%, pulmonary aspiration: 1%, laryngospasm/bronchospasm: 2%). No death was related to these medications. A close monitoring of side effects related to sedation-analgesia must be included in a quality program to improve patient safety in the field. PMID: 14574652 [PubMed - in process]

2: Am J Occup Ther. 2001 Nov-Dec;55(6):649-55.

Validity of using the Assessment of Motor and Process Skills to estimate overall home safety in persons with psychiatric conditions.

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OBJECTIVE: Occupational therapists often base estimates of home safety on their behavioral observations of a client performing functional activities during a hospitalization. To examine this practice, this study investigated the predictive validity of the Assessment of Motor and Process Skills (AMPS) to the overall home safety of persons with psychiatric conditions associated with cognitive impairments. **METHOD:** Ability in activities of daily living (ADL) of 20 participants was evaluated with the AMPS before discharge from an inpatient psychiatric unit. Within approximately 2 weeks of their discharge, the participants' home safety was evaluated within their home settings using the Safety Assessment of Function and the Environment for Rehabilitation. To form a basis for comparison, a second administration of the AMPS was administered concurrently with the home safety evaluation. **RESULTS:** Moderate positive relationships were found between ADL motor and ADL process ability and home

safety in both the clinic and the home; however, analyses of the sensitivity, specificity, and overall predictive values revealed that home ADL process ability was the best predictor of home safety for participants who were categorized as less safe in the study. CONCLUSION: Findings suggest that clinic ADL evaluations using the AMPS give a reasonable estimate of home safety for participants categorized as having more home safety risk. For participants categorized as having less home safety risk, clinic ADL evaluation using the AMPS produced significantly less accurate estimates than ADL evaluations conducted in the home. These results indicate that home safety estimates may be most accurate if they are based on home rather than clinic ADL process ability measures.

Publication Types:

Validation Studies

PMID: 12959229 [PubMed - indexed for MEDLINE]

3: Anaesthesia. 2003 Oct;58(10):945-8.

Avoiding adverse outcomes when faced with 'difficulty with ventilation'.

Bell D.

Publication Types:

Editorial

PMID: 12969034 [PubMed - indexed for MEDLINE]

4: AORN J. 2003 Oct;78(4):667-9.

Patient safety legislation.

Beu B.

Government Affairs Department, USA.

PMID: 14575190 [PubMed - in process]

5: Chest. 2003 Oct;124(4):1584-93.

Inhaled fluticasone propionate by diskus in the treatment of asthma: a comparison of the efficacy of the same nominal dose given either once or twice a day.

Purucker ME, Rosebraugh CJ, Zhou F, Meyer RJ.

Division of Pulmonary and Allergy Drug Products, Center for Drug Evaluation and Research, US Food and Drug Administration, Rockville, MD 20857, USA.

STUDY OBJECTIVE: In September 2000, the US Food and Drug Administration (FDA) approved the use of Flovent Diskus (FD) [fluticasone propionate;

GlaxoSmithKline; Research Triangle Park, NC], which is an orally inhaled, dry-powder corticosteroid, for the maintenance treatment of asthma at dosages of 50 to 1,000 microg administered twice-daily. Once-daily dosage regimens did not receive approval. This article will detail six clinical trials, five of which incorporated comparative once-daily and twice-daily treatment arms of the same nominal dose of FD. DESIGN: Six 12-week, randomized, double-blind, placebo-controlled studies in patients with mild-to-moderate asthma, including two pediatric asthma trials (patient age, 4 to 11 years) of total daily doses of fluticasone propionate (FP) of 100 or 200 microg, and four adult and adolescent studies of total daily doses of FP of 100, 200, or 500 microg. RESULTS:

Twice-daily dosing was numerically superior to once-daily dosing at the same nominal dose in all comparative studies for the primary end point, change in predose FEV(1). In five trials, the results of the once-daily dosage of FP were statistically indistinguishable from those with placebo. One trial demonstrated the superiority of FP, 500 microg once-daily, over placebo; however, the effect size was half that observed with twice-daily dosing. Once-daily FP dosing showed no advantage in safety or in patient adherence to medication. CONCLUSIONS: In

the FDA review of once-daily dosing of the FD regimen, 100 or 200 microg once-daily dosing was not shown to be significantly better than placebo. FP 500 microg once-daily was found to be superior to placebo, but at about one half the effect size as the same nominal dose given bid. No advantage in patient safety or adherence was demonstrated for once-daily administration over twice-daily administration, and once-daily administration is not currently recommended. PMID: 14555594 [PubMed - in process]

6: Clin Otolaryngol. 2003 Oct;28(5):411-6.

Audit-derived guidelines for training in endoscopic sinonasal surgery (ESS)--protecting patients during the learning curve.

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The objective of the present study is to propose guidelines to ensure safe practice in teaching centres while allowing endoscopic sinonasal surgery (ESS) training to proceed. A prospective complications audit of ESS procedures was undertaken over a 5-year period (January 1996-December 2000). The results have been used to form specific guidelines for safe and effective ESS training. A total of 500 patients underwent ESS during the 5-year period. The senior author was the main surgeon in 55% of cases with the trainee observing or assisting. A supervised trainee was the main surgeon in 45% of cases. The overall complication rate was 1.2% (n = 6) (i.e. 0.7% for the 815 procedures performed). These were all minor complications. We encountered no major complications in 500 patients over the 5-year period. This audit shows that training need not compromise patient safety provided it is phased and structured. We propose appropriate phases and suggest the minimum requirements for units involved in ESS training.

PMID: 12969342 [PubMed - in process]

7: Cochrane Database Syst Rev. 2003;(4):CD004423.

Preoperative fasting for adults to prevent perioperative complications.

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BACKGROUND: Fasting before general anaesthesia aims to reduce the volume and acidity of stomach contents during surgery, thus reducing the risk of regurgitation/aspiration. Recent guidelines have recommended a shift in fasting policy from the standard 'nil by mouth from midnight' approach to more relaxed policies which permit a period of restricted fluid intake up to a few hours before surgery. The evidence underpinning these guidelines however, was scattered across a range of journals, in a variety of languages, used a variety of outcome measures and methodologies to evaluate fasting regimens that differed in duration and the type and volume of intake permitted during a restricted fasting period. Practice has been slow to change. **OBJECTIVES:** To systematically review the effect of different preoperative fasting regimens (duration, type and volume of permitted intake) on perioperative complications and patient wellbeing (including aspiration, regurgitation and related morbidity, thirst, hunger, pain, nausea, vomiting, anxiety) in different adult populations. **SEARCH STRATEGY:** Electronic databases, conference proceedings and reference lists from relevant articles were searched for studies of preoperative fasting in August 2003 and experts in the area were consulted. **SELECTION CRITERIA:** Randomised controlled trials which compared the effect on postoperative complications of different preoperative fasting regimens on adults were included. **DATA COLLECTION AND ANALYSIS:** Details of the eligible studies were independently extracted by two reviewers and where relevant information was unavailable from the text attempts were made to contact the authors. **MAIN RESULTS:** Thirty eight randomised

controlled comparisons (made within 22 trials) were identified. Most were based on 'healthy' adult participants who were not considered to be at increased risk of regurgitation or aspiration during anaesthesia. Few trials reported the incidence of aspiration/regurgitation or related morbidity but relied on indirect measures of patient safety i.e. intra-operative gastric volume and pH. There was no evidence that the volume or pH of participants' gastric contents differed significantly depending on whether the groups were permitted a shortened preoperative fluid fast or continued a standard fast. Fluids evaluated included water, coffee, fruit juice, clear fluids and other drinks (e.g. isotonic drink, carbohydrate drink). Participants given a drink of water preoperatively were found to have a significantly lower volume of gastric contents than the groups that followed a standard fasting regimen. This difference was modest and clinically insignificant. There was no indication that the volume of fluid permitted during the preoperative period (i.e. low or high) resulted in a difference in outcomes from those participants that followed a standard fast. Few trials specifically investigated the preoperative fasting regimen for patient populations considered to be at increased risk during anaesthesia of regurgitation/aspiration and related morbidity. REVIEWER'S CONCLUSIONS: There was no evidence to suggest a shortened fluid fast results in an increased risk of aspiration, regurgitation or related morbidity compared with the standard 'nil by mouth from midnight' fasting policy. Permitting patients to drink water preoperatively resulted in significantly lower gastric volumes. Clinicians should be encouraged to appraise this evidence for themselves and when necessary adjust any remaining standard fasting policies (nil-by-mouth from midnight) for patients that are not considered 'at-risk' during anaesthesia.

PMID: 14584013 [PubMed - in process]

8: Drug Saf. 2003;26(13):937-50.

Reducing medication errors : a regional approach for hospitals.

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Since the Institute of Medicine's report, To Err Is Human, and the subsequent publication, Crossing the Quality Chasm, the subject of reducing medical errors has gained considerable attention from patients, healthcare providers, employers and government organisations in the US. Most nonoperative errors are related to medications. Medication errors lead not only to negative repercussions subjectively experienced by both the patient and the healthcare staff, but also to additional expenditures due to complications. Education, adapting new safety systems and technology, and having clinical pharmacists play a larger role in the medication process can all help in solving the problem of medication errors. Designing and executing a rational system to reduce medication errors is particularly germane in the current era of increased demands for quality healthcare in the setting of cost-containment pressures. In the Delaware Valley (Philadelphia and surrounding area) of Pennsylvania, USA, a consortium of healthcare providers in cooperation with the Health Care Improvement Foundation (HCIF), and two non-profit organisations - the ECRI (formerly the Emergency Care Research Institute) and the Institute for Safe Medication Practices (ISMP) - have combined to establish and promote safe medication practices under a programme known as the Regional Medication Safety Program for Hospitals. At the core of the programme are 16 medication safety goals, which centre on establishing an institutional culture of safety, modifying infrastructure and clinical practice to reflect this culture, and using technology to facilitate these changes. It is believed that this rational campaign to improve patient

safety may serve as a paradigm for other regions around the world.

PMID: 14583069 [PubMed - in process]

9: Emerg Med J. 2003 Sep;20(5):402-405.

Emergency department overcrowding in the United States: an emerging threat to patient safety and public health.

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Numerous reports have questioned the ability of United States emergency departments to handle the increasing demand for emergency services. Emergency department (ED) overcrowding is widespread in US cities and has reportedly reached crisis proportions. The purpose of this review is to describe how ED overcrowding threatens patient safety and public health, and to explore the complex causes and potential solutions for the overcrowding crisis. A review of the literature from 1990 to 2002 identified by a search of the Medline database was performed. Additional sources were selected from the references of the articles identified. There were four key findings. (1) The ED is a vital component of America's health care "safety net". (2) Overcrowding in ED treatment areas threatens public health by compromising patient safety and jeopardising the reliability of the entire US emergency care system. (3) Although the causes of ED overcrowding are complex, the main cause is inadequate inpatient capacity for a patient population with an increasing severity of illness. (4) Potential solutions for ED overcrowding will require multidisciplinary system-wide support.

PMID: 12954674 [PubMed - as supplied by publisher]9: Emerg Med Serv. 2003 Sep;32(9):97-100, 102, 104-6.

Medication safety. Implications for EMS.

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PMID: 14503160 [PubMed - indexed for MEDLINE]

10: Health Aff (Millwood). 2003 Sep-Oct;22(5):157-65.

Pittsburgh Regional Healthcare Initiative: a systems approach for achieving perfect patient care.

Sirio CA, Segel KT, Keyser DJ, Harrison EI, Lloyd JC, Weber RJ, Muto CA, Webster DG, Pisowicz V, Feinstein KW.

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The Pittsburgh Regional Healthcare Initiative (PRHI) is an innovative model for health system change based on regionwide shared learning. By linking patient outcomes data with processes of care and sharing that information widely, PRHI supports measurable improvements in regionwide clinical practice and patient safety. In addition, through the redesign of problem solving at the front lines of care, PRHI helps health care organizations to evolve toward becoming sustainable systems of perfect patient care. This paper describes PRHI's design for change, reviews the progress and limitations of the shared learning model, and offers a set of broader policy considerations.

PMID: 14515891 [PubMed - in process]

11: Healthcare Benchmarks Qual Improv. 2003 Oct;10(10):suppl 1-3.

Patient safety alert. Hospital safety initiative targets behavioral health unit.

[No authors listed]
PMID: 14535137 [PubMed - in process]

12: Healthcare Benchmarks Qual Improv. 2003 Oct;10(10):suppl 3-4.
Patient safety alert. Study shows safety risks for children, value of tool.
[No authors listed]
PMID: 14535138 [PubMed - in process]

13: Hosp Case Manag. 2003 Oct;11(10):suppl 1-3.
Patient safety alert. Hospital safety initiative targets behavioral health unit.
[No authors listed]
PMID: 13677701 [PubMed - indexed for MEDLINE]

14: Hosp Case Manag. 2003 Oct;11(10):148-9.
Follow-up system aims to improve patient safety.
[No authors listed]
PMID: 13677694 [PubMed - indexed for MEDLINE]

15: Hosp Case Manag. 2003 Oct;11(10):suppl 3-4.
Patient safety alert. Study shows safety risks for children, value of tool.
[No authors listed]
PMID: 13677702 [PubMed - indexed for MEDLINE]

16: Hosp Peer Rev. 2003 Sep;28(9):117-20.
JCAHO revisits patient safety goals: what your facility must do to comply.
[No authors listed]
PMID: 12953362 [PubMed - indexed for MEDLINE]

17: J Cardiovasc Manag. 2003 Sep-Oct;14(5):11-5.
Using performance improvement strategies to reduce and prevent medication errors. 1.
Bumpus L, al-Assaf AF.
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The headlines feature tragic stories describing errors in medical practice. Medical literature reveals that errors in medical practice are common. In 1999, the Institute of Medicine released its report. "To Err is Human," that detailed an estimated 44,000 to 98,000 deaths annually due to medical errors. In September of 2002, the Archives of Internal Medicine released a study of medication errors observed in 36 healthcare facilities. Medication errors were commonly occurring in 19% or nearly one error out of every five doses administered in a typical hospital. It is imperative to analyze patient safety issues related to medication administration. This paper presents methods to improve the quality of care delivered by: Building effective structures through efficient use of technology. Establishing improved process through collaboration and team-work. Measuring and reporting performance outcomes. Using Performance improvement Strategies to Reduce and Prevent Medication Errors.
PMID: 14567268 [PubMed - in process]

18: J Gerontol A Biol Sci Med Sci. 2003 Sep;58(9):M813-9.
Patient safety in geriatrics: a call for action.
Tsilimingras D, Rosen AK, Berlowitz DR.
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Patient safety has become a major public health concern following the

publication of the landmark report, *To Err Is Human*, by the Institute of Medicine in 1999. This report, along with a subsequent report, *Crossing the Quality Chasm*, recommended the design of a safer health care system by integrating well-established safety methods to avert medical errors. However, neither patient safety report specifically addressed the implications of safety for elderly patients. This article examines those implications by describing the association between aging and medical errors, identifying geriatric syndromes as medical errors, and focusing on six recommendations that will improve the safety of geriatric care. These six recommendations include the detection and reporting of geriatric syndromes, identifying system failures when geriatric syndromes occur, establishing dedicated geriatric units, improving the continuity of care, reducing adverse drug events, and improving geriatric training programs.

PMID: 14528037 [PubMed - in process]

19: *J Healthc Inf Manag*. 2003 Fall;17(4):29-35.

Who's counting now? ROI for patient safety IT initiatives.

Newell LM, Christensen D.

The impact and expectation of cost-justifying patient safety IT initiatives using a traditional ROI must evolve to focus beyond the financial benefit. It must encompass overall patient safety, patient satisfaction, and employee and physician satisfaction benefit categories. Computerized physician order entry (CPOE) and bar code medication administration (BCMA) systems are two particular clinical point-of-care products that will play a key role in addressing patient safety objectives. Integrating the two technologies can bring both financial and clinical benefits.

PMID: 14558369 [PubMed - in process]

20: *J Healthc Inf Manag*. 2003 Fall;17(4):36-41.

Clinical ROI: not just costs versus benefits.

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Although sophisticated economic modeling can be used to quantify intangible benefits, ROI calculations for clinical information systems are driven more by the values and strategic direction of an organization than by any other considerations. But investing in clinical information tools to ensure quality and patient safety is, in reality, required as a cost of doing business and functioning as a safe hospital.

PMID: 14558370 [PubMed - in process]

21: *J Infus Nurs*. 2003 Sep-Oct;26(5):311-8.

Medication safety in home infusion care.

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Enhancing medication safety continues to be a critical focus area in healthcare. Barriers to improving safety include a culture of blaming individuals, underreporting of errors, and neglecting to analyze and improve systems. This article describes why medication safety should be linked with a non-punitive reporting system. Drug safety issues specific to home infusion care are identified, with practical recommendations for enhancing safety and reducing medication errors. Included in this discussion is the sentinel event alert for infusion equipment free flow and the JCAHO Patient Safety Goals for 2003.

Publication Types:

Review Review, Tutorial

PMID: 14506364 [PubMed - indexed for MEDLINE]

22: J Nurs Adm. 2003 Oct;33(10):507-8.

Do no harm: provider perceptions of patient safety.

Hansen MM, Durbin J, Sinkowitz-Cochran R, Vaughn A, Langowski M, Gleason S.
Iowa Department of Public Health, Des Moines, 50311, USA.

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PMID: 14551467 [PubMed - in process]

23: JAMA. 2003 Oct 8;290(14):1868-74.

Comment in:

JAMA. 2003 Oct 8;290(14):1917-9.

Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization.

Zhan C, Miller MR.

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CONTEXT: Although medical injuries are recognized as a major hazard in the health care system, little is known about their impact. OBJECTIVE: To assess excess length of stay, charges, and deaths attributable to medical injuries during hospitalization. DESIGN, SETTING, AND PATIENTS: The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs) were used to identify medical injuries in 7.45 million hospital discharge abstracts from 994 acute-care hospitals across 28 states in 2000 in the AHRQ Healthcare Cost and Utilization Project Nationwide Inpatient Sample database. MAIN OUTCOME MEASURES:

Length of stay, charges, and mortality that were recorded in hospital discharge abstracts and were attributable to medical injuries according to 18 PSIs.

RESULTS: Excess length of stay attributable to medical injuries ranged from 0 days for injury to a neonate to 10.89 days for postoperative sepsis, excess charges ranged from 0 dollar for obstetric trauma (without vaginal instrumentation) to 57 727 dollars for postoperative sepsis, and excess mortality ranged from 0% for obstetric trauma to 21.96% for postoperative sepsis ($P < .001$). Following postoperative sepsis, the second most serious event was postoperative wound dehiscence, with 9.42 extra days in the hospital, 40 323 dollars in excess charges, and 9.63% attributable mortality. Infection due to

24: JAMA. 2003 Oct 8;290(14):1899-905.

Safety of patients isolated for infection control.

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CONTEXT: Hospital infection control policies that use patient isolation prevent nosocomial transmission of infectious diseases, but may inadvertently lead to patient neglect and errors. OBJECTIVE: To examine the quality of medical care received by patients isolated for infection control. DESIGN, SETTING, AND PATIENTS: We identified consecutive adults who were isolated for methicillin-resistant *Staphylococcus aureus* colonization or infection at 2 large North American teaching hospitals: a general cohort (patients admitted with all diagnoses between January 1, 1999, and January 1, 2000; $n = 78$); and a disease-specific cohort (patients admitted with a diagnosis of congestive heart failure between January 1, 1999, and July 1, 2002; $n = 72$). Two matched controls were selected for each isolated patient ($n = 156$ general cohort controls and $n = 144$ disease-specific cohort controls). MAIN OUTCOME MEASURES: Quality-of-care measures encompassing processes, outcomes, and satisfaction. Adjustments for

study cohort and patient demographic, hospital, and clinical characteristics were conducted using multivariable regression. RESULTS: Isolated and control patients generally had similar baseline characteristics; however, isolated patients were twice as likely as control patients to experience adverse events during their hospitalization (31 vs 15 adverse events per 1000 days; $P < .001$). This difference in adverse events reflected preventable events (20 vs 3 adverse events per 1000 days; $P < .001$) as opposed to nonpreventable events (11 vs 12 adverse events per 1000 days; $P = .98$). Isolated patients were also more likely to formally complain to the hospital about their care than control patients (8% vs 1%; $P < .001$), to have their vital signs not recorded as ordered (51% vs 31%; $P < .001$), and more likely to have days with no physician progress note (26% vs 13%; $P < .001$). No differences in hospital mortality were observed for the 2 groups (17% vs 10%; $P = .16$). CONCLUSION: Compared with controls, patients isolated for infection control precautions experience more preventable adverse events, express greater dissatisfaction with their treatment, and have less documented care.

PMID: 14532319 [PubMed - indexed for MEDLINE]

25: JAMA. 2003 Oct 8;290(14):1917-9.

Comment on:

JAMA. 2003 Oct 8;290(14):1868-74.

Looking for medical injuries where the light is bright.

Weingart SN, Iezzoni LI.

Publication Types:

Comment

Editorial

PMID: 14532322 [PubMed - indexed for MEDLINE]

26: Jt Comm J Qual Saf. 2003 Oct;29(10):503-11.

Does full disclosure of medical errors affect malpractice liability? The jury is still out.

Kachalia A, Shojania KG, Hofer TP, Piotrowski M, Saint S.

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BACKGROUND: Mandatory disclosure of medical errors has been advocated to improve

patient safety. Many resist mandatory disclosure policies because of concerns about increasing malpractice exposure. It has been countered that malpractice liability actually decreases when there is full disclosure of medical errors. A comprehensive literature search was conducted to determine what is known about the impact of full disclosure on malpractice liability. METHODS: Electronic searches of multiple databases were supplemented with hand searches of bibliographies and communication with recognized experts in the field. RESULTS: Screening the titles, abstracts, and, in many cases, the full articles from more than an estimated 5,200 citations resulted in identification of one published study directly examining malpractice liability when a policy of full disclosure was implemented. DISCUSSION: Despite extensive literature on the impact of disclosure on malpractice liability, few well-designed studies have focused on the real-world impact on the volume and cost of suits following implementation of a full disclosure policy. Many articles examine why patients sue their doctors, suggesting that some lawsuits may be averted by disclosure, but the articles do not allow us to estimate the additional suits that would be created by disclosure. Additional studies addressing the effect of disclosure on malpractice liability are needed.

PMID: 14567259 [PubMed - in process]

27: Jt Comm J Qual Saf. 2003 Oct;29(10):551-5.

Unanticipated harm to patients: deciding when to disclose outcomes.

Barron WM, Kuczewski MG.

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BACKGROUND: Patient safety standards of the Joint Commission on Accreditation of Healthcare Organizations require that "patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes." WHAT OUTCOMES SHOULD TRIGGER DISCLOSURE: Given that all medical

treatments have an array of possible outcomes, how do we confidently say that an outcome is unanticipated? It is proposed that an adverse outcome meet one of two criteria to be considered unanticipated: (1) It would not be included in a reasonable informed consent process for treatment of the patient's condition(s) and/or would not be expected during the usual course of treatment; and (2) it may have been caused by human or systemic error--that is, it is not immediately possible to clearly and decisively rule out error. This definition requires less judgment because it represents an extension of the existing norms of communication that are expressed through the process of informed consent. The norms of the informed consent process require that the patient be given all pertinent information needed to participate in future treatment decision making.

CONCLUSIONS AND RECOMMENDATIONS FOR ORGANIZATIONAL POLICIES:

Institutional

policies and procedures should provide a clear approach to the identification, reporting, and discussion of unanticipated adverse outcomes, whether or not they are associated with error, as well as guidance and an educational program to help physicians, staff, and students disclose unanticipated adverse events and error in the most appropriate manner.

PMID: 14567264 [PubMed - in process]

28: Miss RN. 2003 Fall;65(3):18.

Nurse leaders take action on range of workplace and patient safety issues.

[No authors listed]

PMID: 14560431 [PubMed - in process]

29: N Engl J Med. 2003 Oct 2;349(14):1311-2.

Comment on:

N Engl J Med. 2003 Oct 2;349(14):1333-40.

Invasive cardiovascular procedures--optimizing patient safety.

Hirshfeld JW Jr.

University of Pennsylvania School of Medicine, Philadelphia, USA.

Publication Types:

Comment

PMID: 14523137 [PubMed - indexed for MEDLINE]

30: Transfusion. 2003 Oct;43(10):1347-50.

FDA approach to evaluation of pathogen reduction technology.

Epstein JS, Vostal JG.

Publication Types:

Editorial

PMID: 14507263 [PubMed - indexed for MEDLINE]

31: Transplantation. 2003 Sep 27;76(6):977-83.

Efficacy and safety of itraconazole prophylaxis for fungal infections after

orthotopic liver transplantation: a prospective, randomized, double-blind study. Sharpe MD, Ghent C, Grant D, Horbay GL, McDougal J, David Colby W. Department of Anesthesia, and Program in Critical Care Medicine, University of Western Ontario, London, Ontario, Canada. michael.sharpe@lhsc.on.ca

BACKGROUND: There is significant morbidity and mortality related to fungal infections in the solid-organ transplant population. **METHODS:** A prospective, randomized, double-blind, placebo-controlled, restricted sequential design trial was performed in 71 adults undergoing orthotopic liver transplantation. Patients were randomly assigned to receive either itraconazole (5.0 mg/kg orally, preoperatively, 2.5 mg/kg orally, two times a day, postoperatively) or placebo. Therapy continued for a maximum of 56 days or until patient was discharged from hospital or met a predefined endpoint. Measurements included incidence of fungal colonization, superficial or systemic fungal infections requiring systemic therapy, adverse events, and mortality rate. **RESULTS:** This trial design supported the superiority of itraconazole in preventing fungal infections; nine